PRINTED: 07/28/2015 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		17E210	B. WING _			07/:	20/2015
NAME OF PROVIDER OR SUPPLIER WESTVIEW MANOR OF PEABODY			STREET ADDRESS, CITY, STATE, ZI 500 PEABODY PEABODY, KS 66866	P CODE			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ((EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	ACTION SHOULD BI O THE APPROPRIA		(X5) COMPLETION DATE
F 000	INITIAL COMMENTS		F 0	000			
F 371 SS=F	complaint investigation 483.35(i) FOOD PRO STORE/PREPARE/S The facility must - (1) Procure food from considered satisfacto authorities; and	sources approved or ry by Federal, State or local stribute and serve food	F 3	771			
	by: The facility had a cer on observation, intervious facility failed to maintation oven in 1 of 1 kitchen the 51 residents who Findings included: Review of the June schedule revealed the trap, after each use, of staff, just a line market. Staff to clean the	2015 daily kitchen cleaning e following: e grill, including the grease or as needed (not initialed by ed through) e stove top and oven, and sprinkler heads after each					

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES (X1) AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MUL A. BUILDI		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		17E210	B. WING		C 07/20/2015
NAME OF PROVIDER OR SUPPLIER WESTVIEW MANOR OF PEABODY			STREET ADDRESS, CITY, STATE, ZIP CODE 500 PEABODY PEABODY, KS 66866	•	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETION
F 371	Continued From pag	e 1	F 37	1	
	Review of the June 2 schedule revealed th	2015 weekly kitchen cleaning e following:			
	· Staff to clean ou (initialed once, undat	t the left side of the oven red)			
	· Staff to clean the grill (initialed once, undated)				
	· Staff to clean the once, undated)	e top of the stove (initialed			
	· Staff to clean the (initialed once, undat	e right side of the oven red)			
	Review of the July 20 schedule revealed th	015 daily kitchen cleaning e following:			
	trap, after each use,	e grill, including the grease or as needed (initialed by days just a line marked			
		e stove top and oven, nd sprinkler heads after each daily)			
	Review of the July 20 schedule revealed th	015 weekly kitchen cleaning e following:			
	· Staff to clean ou (initialed once, undat	t the left side of the oven ed)			
	· Staff to clean the	e grill (initialed once, undated)			
	· Staff to clean the once, undated)	e top of the stove (initialed			
	Staff to clean the (initialed once, undat	e right side of the oven			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		2) MULTIPLE CONSTRUCTION BUILDING		(X3) DATE SURVEY COMPLETED	
		17E210	B. WING			C 07/20/2015	
NAME OF PROVIDER OR SUPPLIER WESTVIEW MANOR OF PEABODY			STREET ADDRESS, CITY, STATE, ZIP COI 500 PEABODY PEABODY, KS 66866	•	07/20/2015		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 371	Continued From pag	e 2	F 3	71			
	the facility's kitchen, top with 6 burners or over the right oven. It revealed, the knobs appliance inoperable splashes of a brown covering the oven do revealed inside the right oven inside the left oven inside the left oven revealed on the top of thick, whitish, gray be of multiple food crum the appliance had m spots. On 7/16/15 at 7:25 A verified the facility's he/she had suggested clean it, several time. On 7/16/15 at 1:48 F staff had daily and word on the grill pilots we flames. The facility's 12/2008 Precaution policy insexhaust hoods, flues gases produced by a stage of the suggested of the stage of t	and multiple drips and and yellow substance pors. Further observation ight side of the oven, the pown, a thick black build up, and a thick black build up. Continued observation of both of the oven doors, a wild up, with the appearance abs in it. The back board of ultiple brown and yellow and Maintenance Staff D poven was dirty, and stated and to the kitchen staff they are. PM, Dietary Staff C stated beekly cleaning duties. PM, Maintenance Staff G at was out of adjustment, are dirty, which caused B Food Service Safety structed staff to keep all a fire, a gas heater, a power burning installation), and					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION IG		COMPLETED	
		17E210	B. WING _			C 07/20/2015	
	NAME OF PROVIDER OR SUPPLIER WESTVIEW MANOR OF PEABODY			STREET ADDRESS, CITY, STATE, ZIP CODE 500 PEABODY PEABODY, KS 66866		07/20/2015	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR ((EACH CORRECTIVE ACTION SHORE) CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 371	Continued From pag	e 3	F3	71			
F 456 SS=F	clean, operating orde 51 residents who res 483.70(c)(2) ESSEN OPERATING COND	TIAL EQUIPMENT, SAFE ITION ntain all essential	F 4	56			
	mechanical, electrica equipment in safe op	•					
	by: The facility had a ce on observation, inter facility failed to main operating condition in	r is not met as evidenced nsus of 51 residents. Based view, and record review the tain 1 of 1 ovens in safe 1 of 1 kitchens which 51 residents who reside in					
	Findings included:						
	the facility's kitchen, top with 6 burners ov over the right oven. (PM, observation revealed in a double gas oven, a stove rer the left oven, and a grill Continued observation ce intact, and able to be					
	the facility's kitchen, top with 6 burners ov over the right oven. (revealed, the knobs appliance inoperable splashes of a brown	M, observation revealed in a double gas oven, a stove rer the left oven, and a grill Continued observation removed leaving the and multiple drips and and yellow substance fors. Further observation					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING			(X3) DATE SURVEY COMPLETED			
		17E210	B. WING			C 7/20/204 <i>E</i>
NAME OF PROVIDER OR SUPPLIER WESTVIEW MANOR OF PEABODY		STREET ADDRESS, CITY, STATE, ZIP CODE 500 PEABODY PEABODY, KS 66866		07/20/2015		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOUNDER OF THE APPREDED TO	JLD BE	(X5) COMPLETION DATE
F 456	revealed inside the ri door seal hanging do inside the right oven, inside the left oven. Or revealed on the top of whitish, gray build up multiple food crumbs appliance had further top of the key for the flames went out, gas. Dietary Staff A vuse the oven until replacility implemented are sidents. On 7/15/15 at 4:26 Perified the kitchen and he/she was waith his/her call. On 7/15/15 at 4:29 Perified the flames with the oven maintenance has to on the stated the oven caughout to use the oven a Dietary Staff C further uncertain as to why set the afternoon before.	ght side of the oven, the own, a thick black build up and a thick black build up Continued observation of both oven doors a thick, with the appearance of in it. The back board of the le brown and yellow spots. M, Dietary Staff A verified on the oven had caught fire after a flames were shooting out burner. Dietary Staff A further able to turn off the oven, then and he/she did not smell perified the facility would not bairs were made, and the	F 456			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULT A. BUILDI	IPLE CONSTRUCTION NG	_	(X3) DATE SURVEY COMPLETED	
		17E210	B. WING			C 07/20/2015
NAME OF PROVIDER OR SUPPLIER WESTVIEW MANOR OF PEABODY				STREET ADDRESS, CITY, S 500 PEABODY PEABODY, KS 66866		07/20/2015
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	(EACH CORR	R'S PLAN OF CORRECTION RECTIVE ACTION SHOULD BE RENCED TO THE APPROPRIA DEFICIENCY)	
F 456	facility and verified th On 7/16/15 at 7:25 Al verified he/she had to temperature in the ov further verified he/she the temperature, and adjusted. Maintenanc something wrong with unable to successfully On 7/16/15 at 8:00 Al verified staff had not an issue with the stov PM on 7/15/15. Admi staff filled out an incic them in his/her box for emitted fire twice whe further verified the sta him/her immediately of On 7/16/15 at 8:40 Al 6:15 AM on 7/15/15, pilot under the grill or so, a flame "whoosh him/her off balance. I he/she notified Dietar unusable, but he/she passed the informatic Dietary Staff E furthe incident report at the approximately 12:30 On 7/16/15 at 9:07 Al verified he/she had in complete an incident placed it in the admin	M, Maintenance Staff D of frequently adjust the en. Maintenance Staff D e came in recently to adjust the oven was unable to be se Staff D verified there is in the oven, if he/she was by adjust it. M, Administrative Staff B informed him/her there was we until approximately 4:00 mistrative Staff B verified dent report, but just placed or review. (after the oven had en lit) Administrative Staff B aff should have notified of the problem. M, Dietary Staff E verified at the/she attempted to light the in the appliance, when doing ed" out, and knocked Dietary Staff E verified by Staff A the oven was did not know if he/she on on to administrative staff. In verified he/she filled out an end of his/her shift, at PM. M, Administrative Staff F instructed Dietary Staff E to report, and he/she had	F	456		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
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NAME OF PROVIDER OR SUPPLIER WESTVIEW MANOR OF PEABODY				STREET ADDRESS, CITY, STATE, ZIP CODE 500 PEABODY PEABODY, KS 66866		•	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 456	verified the thermos and the grill pilots w flames. On 7/16/15 at 1:48 flee/she expected the second time after the and staff were informed for the operable with the kn 7/15/15. On 7/16/15 at 2:00 floor verified he/she would immediately, staff shand place a sign up the appliance. The facility's 12/200 staff not to use defer all hazardous condition. The facility's 12/200 Precaution policy indoor for a few mome allow gas leakage to directed staff to kee duct for smoke and fire, a gas heater, a fuel-burning installating reduce fire danger. The facility failed to oven in safe operation.	tat was out of adjustment, ere dirty, which caused the PM, Dietary Staff C verified e staff not to use the oven a e first incident on 7/15/15, med not to use it. Dietary Staff e appliance had remained hobs intact until the evening of PM, Administrative Staff B d expect to be notified nould not use the appliance, to inform all staff not to use 8 Fire Safety policy instructed ctive equipment and to report	F 4	56			